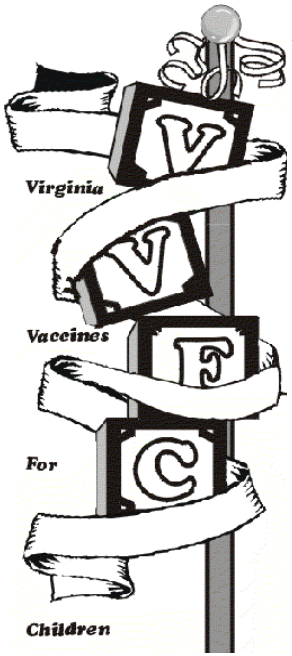

VVFC DOSES ADMINISTERED REPORT

Date Range for Doses Administered: _____

Contact Name _____ **Practice PIN** _____

Practice Name _____ **Submission Date** _____

Address _____ **Phone Number** ( ) _____

City/State/Zip _____ **Fax Number** ( ) _____

INSTRUCTIONS: Record the doses of VVFC-provided vaccines that are administered to VVFC-eligible patients by your practice for a 30-day period. Document actual vaccinations administered to your VVFC patients, rather than estimating. Record the vaccinations in numbers, or if hash marks are used, record totals in the bottom row. Indicate what type of data was used to complete this form by checking a selection below. **This report must be received by the VVFC Office 5 days after 30 days of administration have been documented.**

Data Type Used to Complete this Form: ☐ **Hand Count** ☐ **Billing Data** ☐ **Patient Log** ☐ **Other, Specify:** _____

Vaccine Type / ***Dates***	**DTaP**	**DTaP-Hep B – IPV** (Pediarix)	**DTaP-Hib** (Trihibit)	**Hep B**	**Hep B** (2 dose)	**Hib**	**Hep B – Hib** (Comvax)	**IPV** (Polio)	**Prevnar** (PCV-7)	**MMR**	**Varicella**	**Flu**	**Flu** Preserv. Free	Adult/ Adolest. **Td**	Ped. **DT**	**Hep A**	**PPV-23**
Week 1																	
Week 2																	
Week 3																	
Week 4																	
Week 5																	
TOTALS																	

VVFC use only																	

Division of Immunization, P.O. Box 2448
109 Governor Street, Room 314 West
Richmond, VA 23218

Phone (800) 568-1929
(804) 864-8055
Fax (804) 864-8090 or 8089

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